Certification of Temporary Total Disability

for Stafford, Supplemental Loans for Students (SLS), Parent (PLUS) Loans, and Consolidation Loans

Guarantor

Under the Guaranteed Student Loan Programs, administered by the California Student Aid Commission, a borrower is entitled to have periodic installment payments of principal deferred for up to three years during which time the borrower is temporarily totally disabled, or during which time the borrower is unable to secure employment because he or she is caring for a spouse or dependent who is temporarily totally disabled.

To qualify for this deferment, a borrower must provide the lender who issued the loan or current holder with a request for deferment and a certification from a qualified physician, certifying the borrower's, spouse's, or dependent's disability.

The following certification is for the purpose of establishing the eligibility of a Stafford/SLS/PLUS/Consolidation loan borrower to obtain a deferment for temporary total disability.

Borrower/Spouse/Dependent Certification of Temporary Total Disability

To be completed by borrower:

Name of borrower		Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___		
Street address	City	State	Zip code	Phone number ( )
Name of patient				
Street address	City	State	Zip code	Phone number ( )

The temporary total disability applies to (check one):

- ☐ a borrower of a Stafford/SLS/PLUS/Consolidation loan(s).
- ☐ a spouse or dependent of a borrower of a Stafford/SLS/PLUS/Consolidation loan(s).

Physician's Certification of Temporary Total Disability

To be completed by physician:

I certify that I am legally authorized to practice medicine/osteopathy and that in my professional judgment my patient is unable either to attend school or to be gainfully employed because he or she is temporarily totally disabled. If my patient is the spouse/dependent of a guaranteed student loan borrower, I certify that my patient requires continuous nursing or similar services while he/she is temporarily totally disabled. I declare under penalty of perjury under the laws of the United States of American that the foregoing is true and correct.

Name of physician (print or type)

Street address	City	State	Zip code	Phone number ( )
Physician's signature (M.D. or D.O.) ▶		Date		

When complete, return to lender/holder:

Name: _____

Address: _____

City, state, zip code: _____

Printed for lender use by:
California Loan Programs
P.O. Box 510625
Sacramento, CA 94245-0625